Alachua County Public Schools
Head Start / VPK Program

Verification of Dental Treatment

School:_____

This is to certify that_____ is one of my regular patients and was last seen in my office on_____

The following applies to this patient:

- ☐ Needs no treatment at this time
- ☐ Needs a routine examination in the month of: _____
- ☐ Needs the following services:

_____

_____

_____

- ☐ Appointment scheduled for: _____

Comments:

_____

_____

_____

Provider Stamp

_____
Signature of Dentist

_____
Print Name

_____
Date

As Parent or Legal Guardian of_____, I hereby give my permission for the above information to be released to the Head Start Program.

Parent or Legal Guardian:_____ Date:_____

Dental Provider:_____

Return to: Fearnside Family Services Center, 3600 NE 15 Street, Gainesville, FL 32609-2484
or fax to: 844-273-4664

Form No.: CUR-021-005 – Verification of Dental Treatment / CUR / Head Start
New Date: 4/29/20

Distribution: ___Central File
___Health Coordinator
___Dentist
___Health Team